

Updated 08/07

Name:	Age:	Birth Date:
Physician's Name:	Patient's ID Number:	
Referring Physician / Person:	Today's Date:	

Please describe any special problems or symptoms that you would like to discuss.

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Bone Density		Pelvic Ultrasound		Colonoscopy	
Pap		Mammogram		Cholesterol	
HPV		Cystic Fibrosis		Cystoscopy	
Was last pap:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	If abnormal how treated:		Breast Cancer Gene	

PAST MEDICAL HISTORY

Have you ever had any problems related to:			
Heart / Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional / Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney's / Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine Hormones / Thyroid / Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic System / Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood (anemia, clots, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestive System (colon)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No

SURGERIES and MAJOR INJURIES

Date	Hospital	Surgery Type

CURRENT MEDICATION

Medication	Frequency of Dose	Medication	Frequency of Dose

LATEX ALLERGIES

Are you allergic to latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What type of reaction do you have?	Does reaction interfere with any activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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MEDICATION ALLERGIES

Do you have any medication allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to what?	What type of reaction do you have?	Does reaction interfere with any activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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FOOD ALLERGIES

Do you have any food allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to what?	What type of reaction do you have?	Does reaction interfere with any activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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ENVIRONMENTAL ALLERGIES

Do you have any environmental allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to what?	What type of reaction do you have?	Does reaction interfere with any activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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MENSTRUAL HISTORY

Age period began:	First day of last normal menstrual period - Date:	Length of periods (# of days of bleeding):	Number of days between periods:	Heaviest day of your menstrual flow, how many full-sized pads or tampons would you soak?	
Do you take any medications for your periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any recent changes in periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever have bleeding in between your periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Do you ever have bleeding with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Physician's Name:	Patient's ID Number:
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SEXUAL HISTORY

Present method of birth control:	Have you ever used an intrauterine device (IUD)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes for how long?
Have you ever had sex? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of sexual partners (year):	Sexual partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
Any sex partners use IV drugs, bi-sexual or hemophiliacs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have pain with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had vaginal infections? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had pelvic infections (PID)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had any sexually transmitted diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what type of STD?	Do you desire contraceptive information? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a D.E.S. daughter? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other issues related to sexual activity which you would like to discuss?

REPRODUCTIVE HISTORY

# of times pregnant:	# of deliveries prior to 37 weeks:	# of living children:
# of term deliveries:	# of losses prior to 20 weeks or abortion:	weight of largest baby:
# of c-sections:	reason:	weight of smallest baby:
Has there been a time when you have been having intercourse, have not used contraception, yet have not become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If desiring pregnancy how old is your partner?	Has he ever fathered any children? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does he have any health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type?	

Have you ever had any of the following pregnancy complications:

High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Premature labor <input type="checkbox"/> Yes <input type="checkbox"/> No	Other
Kidney infections <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth defects <input type="checkbox"/> Yes <input type="checkbox"/> No	

If you are pregnant now, have you been exposed to:

Medications <input type="checkbox"/> Yes <input type="checkbox"/> No	Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	X-rays <input type="checkbox"/> Yes <input type="checkbox"/> No	Other
Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	Cats <input type="checkbox"/> Yes <input type="checkbox"/> No	

If you are pregnant now, have you had a rash or viral illness during your pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your family and the father of the fetus' family related in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No
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URINARY HISTORY

Have you had bladder infections? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had kidney infections? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have burning on urination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have blood in your urine? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you lose urine on coughing, sneezing, laughing, running? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so does this require daily pad use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you urinate frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you get up at night to urinate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an uncomfortable bulge in your vagina? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you leak urine with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an urgency to urinate such that you will lose urine if a bathroom is not available? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MENOPAUSAL SYMPTOMS

Are you bothered by hot flashes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you bothered by vaginal dryness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you bothered by difficulty sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other problems that you feel could be related? <input type="checkbox"/> Yes <input type="checkbox"/> No
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FAMILY HISTORY Have any of your close relatives had any of the following conditions?

Condition:	Relation to you	Relation to spouse	Condition:	Relation to you	Relation to spouse
Anemia related to Mediterranean or black ethnicity			High blood pressure		
Chromosomal abnormalities (I.e. Down's Syn.)			Huntington's Chorea		
Neural tube defect (I.e., spina bifida or anencephaly)			Mental retardation		
Birth defects/Genetic disorder			Muscular dystrophy		
Bleeding disorder or blood clot formation			Osteoporosis		
Breast cancer			Ovarian cancer		
Colon cancer			Sickle Cell Disease or trait		
Cystic fibrosis			Tay-Sachs Disease		
Diabetes			Three or more miscarriages		

Physician's Name:			Patient's ID Number:		
ANCESTRY Please indicate if you or your spouse are of the following ancestry.					
Ancestry:	You	Spouse		You	Spouse
Ashkenazi Jewish	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been tested for Tay-Sachs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Black	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been tested for Sickle cell trait?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mediterranean (Italian, Greek)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been told that you had an anemia or been tested for thalassemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Southeast Asian, Philippines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
SOCIAL HISTORY					
Marital Status (circle one) Single Married Widowed Divorced Partnered Engaged Separated			Number of children living at home:		
Patient Employer:			Husband / Patient's Employer		
Name and age of children:					
Do you / did you ever drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What type?		For how many years?			
How much per week?		When did you stop?			
Do you / did you ever use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What type?		For how many years?			
How much per day?		When did you stop?			
Do you / did you ever abuse any other recreational or prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What type?		When did you start?			
How much per day?		When did you stop?			
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How often?					
In the last two (2) years have you used any of the following?					
Speed / Uppers <input type="checkbox"/> Yes <input type="checkbox"/> No	Marijuana <input type="checkbox"/> Yes <input type="checkbox"/> No	Cocaine <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP "Angel Dust" <input type="checkbox"/> Yes <input type="checkbox"/> No		
Quaaludes / Downer <input type="checkbox"/> Yes <input type="checkbox"/> No	Heroin <input type="checkbox"/> Yes <input type="checkbox"/> No	Crack <input type="checkbox"/> Yes <input type="checkbox"/> No	Diet Pills <input type="checkbox"/> Yes <input type="checkbox"/> No		
Tranquilizers that were not prescribed by a doctor <input type="checkbox"/> Yes <input type="checkbox"/> No		Other			
REVIEW OF SYSTEMS Check (✓) symptoms you currently have or have had in the past.					
CONSTITUTIONAL		RESPIRATORY		MUSCULOSKELETAL	
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Cough		<input type="checkbox"/> Difficulty walking up stairs	
<input type="checkbox"/> Fever		<input type="checkbox"/> Coughing up phlegm		<input type="checkbox"/> Muscle or joint pain	
<input type="checkbox"/> Weight gain unexplained in past 3 months		<input type="checkbox"/> Difficulty breathing		SKIN	
<input type="checkbox"/> Weight loss in past 3 months		<input type="checkbox"/> Spitting up blood		<input type="checkbox"/> Rash	
EYES		GASTROINTESTINAL		ENDOCRINE	
<input type="checkbox"/> Blurred or double vision		<input type="checkbox"/> Abdominal bloating		<input type="checkbox"/> Heat or cold intolerance	
EARS, NOSE, THROAT		<input type="checkbox"/> Abdominal pain		<input type="checkbox"/> Night sweats	
<input type="checkbox"/> Difficulty smelling		<input type="checkbox"/> Blood in stool		<input type="checkbox"/> Breast discharge	
<input type="checkbox"/> Ear pain or hearing loss		<input type="checkbox"/> Constipation		NEUROLOGIC	
<input type="checkbox"/> Nasal congestion		<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Dizzy spells	
CARDIOVASCULAR		<input type="checkbox"/> Indigestion		<input type="checkbox"/> Frequent headaches	
<input type="checkbox"/> Swelling of feet or ankles		<input type="checkbox"/> Vomiting		<input type="checkbox"/> Numbness in fingers	
<input type="checkbox"/> Irregular heart beat		<input type="checkbox"/> Difficulty passing stool		<input type="checkbox"/> Weakness	
<input type="checkbox"/> Murmur		HEMATOLOGIC/LYMPHATIC		PSYCHIATRIC	
<input type="checkbox"/> Pain in chest		<input type="checkbox"/> Easy bruising		<input type="checkbox"/> Crying spells	
		<input type="checkbox"/> Enlarged lymph nodes		<input type="checkbox"/> Insomnia	
		<input type="checkbox"/> Easy bleeding		<input type="checkbox"/> Work or family problems	
		<input type="checkbox"/> Bleeding does not stop easily		<input type="checkbox"/> Depression	
				<input type="checkbox"/> Anxiety	
VERIFICATION					
Form Completed By:			Patient Signature:		
<input type="checkbox"/> Patient <input type="checkbox"/> Medical Assistant					
<input type="checkbox"/> Physician _____					
<input type="checkbox"/> Office Nurse (name or initials)					
Date Reviewed By Physician With Patient:			Physician Signature:		



Authorization Form for Release of Protected Health Information under the HIPAA Privacy Law

The name(s) listed below are family or friends whom I grant permission for my healthcare provider and their representatives of SOWC to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account.

Patient Name: _____ **DOB:** _____

The information you may release subject to this authorization is the following:

Appointment date/time **Yes** **No** Explanation of diagnosis and/or procedures **Yes** **No**

Lab reports **Yes** **No** Billing information **Yes** **No**

➤ **I consent to SOWC to leave a message on my voicemail/answering machine about my lab test results** **Yes** **No**

Release my protected health information to the following person(s)/entity:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I do not want any of my information shared with family or friends

I understand that my healthcare information at Seven Oaks Women's Center is protected. I have received this Notice of Privacy Practices and this document will be on record with SOWC.

Patient Signature Date

Witness Signature Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Seven Oaks Women's Center.

Bryan M. Cox, M.D.
Christine DeLaGarza, M.D.
Shannon Gallagher, M.D.
Brian W. Harle, M.D.



Heidi R. Heck, M.D.
Parke J. Hedges, M.D.
Tiffany Satterfield, D.O.

Seven Oaks Women's Center Patient Consent Form

By signing this form, you are granting consent to Seven Oaks Women's Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice before you sign his consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our health information office at: (210) 692-9500.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Name (Print): _____

Signature: _____

Date: _____

Bryan M. Cox, M.D.
Christine DeLaGarza, M.D.
Shannon Gallagher, M.D.
Brian W. Harle, M.D.



Heidi R. Heck, M.D.
Parke J. Hedges, M.D.
Tiffany Satterfield, D.O.

FINANCIAL POLICY

Thank you for choosing Seven Oaks Women's Center as your health care provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy as well as complete our Patient Information form prior to seeing the physician.

Payment for service is due at the time services are rendered. We accept **cash, check, Visa, American Express, Discover** and **MasterCard**. We will be happy to help you process your insurance claim for your reimbursement.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are however, contracted with certain managed care, and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. **All charges are your responsibility whether your insurance company pays or does not pay.** Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. **Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.**
4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. **You will be responsible for any unpaid claims.**
5. If your insurance company does not pay in full within 45 days, we require you to pay the balance by **cash, check, Visa, American Express, Discover, or MasterCard.**
6. **Lab Billing** – Please remember, your lab billing is separate from our physician's billing and you may receive a separate itemized bill from the laboratory, for which you are responsible. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.
7. Returned checks and balances older than 45 days may be subject to collection placement and collection fees.

Please note that, if you must cancel or reschedule your appointment, **all cancellations must be made at least 24 hours in advance.** **If you fail to cancel your appointment, you may be charged at the rate of a normal office visit.** We encourage you to communicate with our business office any payment problems, so that we may assist you in the management of your account. Again, thank you for choosing Seven Oaks Women's Center as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient's Signature: _____ Date: _____



**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
FOR CLINICAL RESEARCH PURPOSES**

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Medical Record: _____

Date of Birth: _____ Social Security # _____

I authorize the following individual or organization to disclose the above named individual's health information:

Seven Oaks Women's Center, 7711 Louis Pasteur, Suite 200, San Antonio, TX 78229 **Yes No**

This information may be disclosed to and used by:

Clinical Trials of Texas, Inc, 7940 Floyd Curl Dr, Suite 700, San Antonio, TX 78229

For the purpose of: Research of Women's Health related drugs and devices.

Please release the following: Complete Record

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer for Seven Oaks Women's Center.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness